Chapter Six
Prior Approval for State to State Transportation

Chapter Overview

Introduction

This chapter provides information on documentation requirements and the prior approval (PA) process required for state-to-state placement by ground or air transport. Out of state ambulance providers must enroll in North Carolina to be an approved provider.

In This Chapter

This chapter covers the following topics:

The Prior Approval Process (PA)

Prior Approval Initiation and Facilitation

The recipient's county Department of Social Services (DSS) initiates and facilitates the prior approval (PA) process. The county DSS verifies the recipient's eligibility on date of service, and that no other resources are available other than Medicaid to pay for the transportation.

Prior Approval Process

The recipient's county DSS contacts EDS Prior Approval unit for instructions by calling EDS: 1-800-688-6696 or 1-919-851-8888. The required forms must be sent to EDS by the requesting facility or physician. EDS will review the PA request and send the ambulance provider a copy of the approved or denied PA form. If approved, a PA number will be provided on the form.

Note:

- each trip requires a separate PA process and PA number
- the PA is required before service is rendered
- the PA is active for 30 days

State-to State Placement Documentation Requirements

Authorization

If a case lacks sufficient medical cause to warrant ambulance transportation, the PA request will be denied as not medically necessary.

Request for Reimbursement

Following provision of service, submit claim form UB-92 to request reimbursement for services. The 9-digit PA number must be entered in form locator 63.

A claim billed without a PA number will be denied.

Documentation Maintenance

Maintain in the provider files the call report, PA form, and any documentation prepared or received in regard to the service for a period of not less than five (5) years from the date of service.

Forms and Instructions for Prior Approval

Prior Approval Forms

The following forms are used to request authorization for state-to-state ambulance transportation.

- Medicaid Prior Approval Form 372-118
- State-to-State Ambulance Transportation Addendum 372-118A

See Appendix B for EDS Prior Approval Unit address.

Continued on next page

Forms and Instructions for Prior Approval, continued

Request for Prior Approval Form 372-118 Instructions

Follow the instructions below to complete the form.

1. **Prior Authorization Number**: Leave blank. This will be completed by the prior approval analyst if the service is determined to be medically necessary
2. **Patient Name**: Enter the patient's full name (last name, first name, middle initial) as indicated on the Medicaid Identification Card
3. **Medicaid Identification Number**: Enter the patient's 10-digit recipient identification number which is found on Medicaid Identification Card issued monthly to eligible recipients
4. **Date of Birth**: Enter the patient's date of birth using six digits (Example: September 18,1930, would be recorded 09/18/30). This information can be found on the Medicaid Identification Card (Note: Notification of increase to 8 digits for Y2K compliance will be forthcoming.)
5. **Diagnosis**: Required
6. **ICD 9th Edition**: Not Required

   Type of Request: Check block 05 and enter the word "ambulance"
7. **Brief Summary of Clinical Findings**: Required
8. **Retroactive Date(s) Requested From**: Leave blank (to be used in cases of retroactive eligibility only)
9. **Retroactive Date(s) Requested To**: Leave blank.
10. **Procedure To Be Performed**: Enter one of the following appropriate descriptions indicating the type of transportation:

    A. "State-to-State Air Ambulance"

    B. "State-to-State Ground Ambulance"
11. **Procedure Code**: Enter the appropriate procedure code
12. **Reason Procedure Is Necessary To Patient's Health**: Required
13. **Has Patient Been Previously Provided With This Service**: Not Required
14. **Physician Signature**: Required
15. **Provider's Number**: Enter the 7-digit Medicaid Ambulance provider billing number if known
16. **Date**: Required
17. **Place of Service**: Not Required

    EDS Use Only: Leave blank. This will be completed by the prior approval analyst to indicate the prior approval determination.
18. **Provider Name and Mailing Address**: Type, print, or stamp the ambulance name and mailing address. It is important that this item be completed legibly.

Continued on next page

Forms and Instructions for Prior Approval, continued

Form 372-118A Instructions

Follow the instructions below to complete the form.

A. **Patient Name and Address**: Enter the patient's full name and address

B. **Attending Physician Name and Number**: Enter the physician's name and Medicaid provider number

C. **Facility (Point of Pickup)**: Indicate where the patient will be picked up by the ambulance (name and address of the institution or address of residence)

D. **Facility (Destination)**: Indicate where the patient will be transported to by ambulance (name and address of institution/facility or address of residence)

E. **Date of Service**: Enter the anticipated or scheduled date of service

F. **Signature/Title and Date**: The county's authorized person must validate the "no other resources" statement by signature, title and date

G. **County, Telephone Number and Contact Person**: Enter the county name, telephone number including area code, and name of the contact person

EDS: INSERT REQUEST FOR PRIOR APPROVAL FORM 372-118

Mail to: EDS
P.O. Box 31188
Raleigh, NC 27622

STATE TO STATE AMBULANCE TRANSPORTATION ADDENDUM

A. Patient Name _____

Address _____

_____

B. Attending Physician_____

Name and Number _____

C. Facility (Point of Pickup) _____

_____

D. Facility (Destination) _____

_____

E. Date of Service _____

Letter (signed by attending physician), which includes

Medical diagnosis
Recipient's physical condition
Ambulance transportation justification

F. I verify that there are no resources other than Medicaid to pay for the transportation:

_____ _____

(Signature/Title) **(Date)**

G. County _____

Telephone Number_____

Contact Person _____

372-118A